STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	12/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000		K010000		

A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 10/16/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).

Survey Date: 12/15/14

Facility Number: 000369
Provider Number: 155530
AIM Number: 100275190

Surveyor: Brett Overmyer, Life Safety Code Specialist

At this Life Safety Code survey, South Shore Health & Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.

This one story facility with a partial basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	12/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	system with smoke detection on all levels including the corridors, areas open to the corridors, and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 129 with a census of 69 at the time of the survey. Quality Review by Dennis Austill, Life Safety Code Specialist on 12/16/14. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the wooden shed in the back used for maintenance storage.			
K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure two doors in 1 of 1 locked emergency exits were accessible at all times. LSC 7.1.10.1 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. This deficient practice would affect all residents, visitors and staff that reside in the Unit 4 wing.	K010038	The facility will ensure that all exit doors are accessible at all times The exit doors identified during the survey will be repaired Doors will open with little effort All exits will be checked to ensure proper functioning All doors will function properly Environmental Director or designee will audit doors at least weekly to ensure continued proper functioning Results of audits will be reported to the QA Team monthly to ensure continued compliance	01/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	12/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on observation and interview with the maintenance director on 12/15/14 at 11:50 a.m., the maintenance director attempted to open the Unit 4 west end egress exit double door. The maintenance director had to push hard on the right side of the door to open. The left side of the door had to be forcibly opened by pushing hard and kicking the door. The maintenance director then had to slam the door to get the door to close properly. The maintenance director acknowledged the aforementioned deficiency. This deficiency was cited on 10/16/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 3.1-19(b)			
K010044 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 2 of 4 fire door sets would latch into the door frame. LSC 7.1.3.2.1 requires openings in the	K010044	The facility will ensure that all fire doors latch into their frames at all times The fire doors identified during the survey will be repaired All fire doors will be checked to ensure proper functioning All fire	01/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	12/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	separation be protected by fire door assemblies equipped with door closures complying with 7.2.1.8. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-.1.2 requires fire door assemblies to include latches. NFPA 80, 2-1.4 requires all fire doors to be closed and latched at the time of a fire. This deficient practice affects any resident, visitor, and staff using the Units 2 & 3 and the Main Dining room.. Findings include: Based on observation and interview on 12/15/14 at 12:00 p.m. with the maintenance director, the fire door with a 1 ½ hour fire resistance rating and separated the existing Unit 3 Hall from the Main Dining room had a positive latching mechanism for the door but failed to latch into the frame. This was verified by the maintenance director at the time of observation. This deficiency was cited on 10/16/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 3.1-19(b)		doors will function properly Environmental Director or designee will audit fire doors at least weekly to ensure continued proper functioning Results of audits will be reported to the QA Team monthly to ensure continued compliance	